5101:3-12-02 **Private duty nursing: services, provision requirements, coverage and service specification.**

(A) "Private duty nursing (PDN)" is a continuous nursing service that requires the skills of and is performed by either a registered nurse or licensed practical nurse at the direction of a registered nurse. A continuous nursing visit is defined as a medically necessary visit that is more than four hours (more than sixteen units) but less than or equal to twelve hours (forty-eight units) in length, unless an unusual, occasional circumstance requires a medically necessary visit up to and including sixteen hours (sixty-four units). A service is not considered a nursing service merely because it was performed by a licensed nurse.

(B) For PDN to be covered, the service:

(1) Must be performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.

(2) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(3) Must be provided in a face-to-face encounter.

(4) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(5) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-06 of the Administrative Code.

(6) Must be provided in the consumer's place of residence unless it is medically necessary for a nurse to accompany the consumer in the community. The consumer's place of residence is wherever the consumer lives, whether the residence is the consumer's own dwelling, an apartment, assisted living facility, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). The place of service in the community cannot include the residence or business location of the provider of PDN.

(7) Must not be provided for the provision of habilitative care. "Habilitative care" is referenced in Chapter 5101:3-1 of the Administrative Code.

(8) Must meet the criteria in accordance with this paragraph and paragraphs (A), (C) and (D) of this rule.

(9) For "children" (consumers under the age of twenty-one), must also meet the criteria in accordance with either paragraph (E) or (F) of this rule.

(10) For "adults" (consumers age twenty-one and older), must also meet the criteria in accordance with either paragraph (E) or (G) of this rule.

(C) The providers of PDN are: MCRHHAs (medicare certified home health agencies) that meet the requirements in accordance with rule 5101:3-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5101:3-12-03.1, and a non-agency nurse that meets the requirements in accordance with rule 5101:3-12-03.1 of the Administrative Code. In order for PDN to be covered, these providers must:

(1) Provide PDN that is appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as documented by the consumer's treating physician.

(2) Provide PDN as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. Additionally, for consumers enrolled on an HCBS waiver, the providers of PDN services must provide the amount, scope, duration, and type of PDN service within the plan of care as:

(a) Identified on the all services plan that is approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS administered home and community based services (HCBS) waiver. PDN services not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA (Ohio department of aging) administered or an ODMR/DD (Ohio department of mental retardation and developmental disabilities) administered HCBS waiver. PDN services not documented on the services plan are not reimbursable.

(3) Bill for provided PDN services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-06 of the Administrative Code.

(4) Bill for provided PDN services in accordance with the visit policy in rule 5101:3-12-04 of the Administrative Code.

(5) Bill after all documentation is completed for services rendered during a visit in accordance with rule 5101:3-12-03 of the Administrative Code.

(D) Consumers who receive PDN must:

(1) Be under the supervision of a treating physician who is providing care and treatment to the consumer. The treating physician cannot be a physician

whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

(2) Participate in the development of a plan of care with the treating physician and the MCRHHA or other accredited agencies or non-agency registered nurse. An authorized representative may participate in the development of the plan of care in lieu of the consumer.

(3) Access PDN in accordance with the program for the all-inclusive care of the elderly (PACE) if the consumer participates in the PACE program.

(4) Access PDN in accordance with the consumer's provider of hospice services if the consumer has elected hospice.

(5) Access PDN in accordance with the consumer's managed care plan if the consumer is enrolled in a medicaid managed care plan.

(E) Post Hospital - PDN:

(1) Any medicaid consumer, whether adult or child, may receive PDN services up to fifty-six hours (two hundred twenty-four units) per week, and up to sixty consecutive days from the date of discharge from an inpatient hospital stay of three or more covered days in accordance with rule 5101:3-2-03 of the Administrative Code. For purposes of this rule, a covered inpatient hospital stay is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location.

(a) The sixty days will begin once the consumer is discharged from the hospital to the consumer's place of residence as defined in paragraph (B)(6) of this rule, from the last inpatient stay whether or not the last inpatient stay was in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(b) The sixty days will begin once the consumer is discharged from a hospital to a nursing facility. PDN is not available while residing in a nursing facility.

(2) The treating physician or a hospital discharge planner or a registered nurse acting under the orders of the treating physician certifies the medical necessity of PDN services using the JFS 07137 "Home Care Physician Certification Form" (rev. 7/2006). PDN is available to consumers only if they have a medical need comparable to a skilled level of care as evidenced by a medical condition that temporarily reflects the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code. In no instance do

these requirements constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long-term care institution.

(3) The PDN service must not be for the provision of maintenance care. "Maintenance care" is the care given to a consumer for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the consumer is no longer making significant improvement in his or her medical condition.

(4) All requirements must be met in paragraph (E) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(5) Consumers who require additional PDN with or without a hospitalization may access PDN through either paragraph (F) or (G) of this rule.

(F) Child - PDN:

(1) A child may qualify for PDN services if he or she meets the requirements within paragraph (F) of this rule.

(a) Is under age twenty-one and requires services for treatment in accordance with Chapter 5101:3-14 of the Administrative Code for the healthchek program.

(b) Requires (as ordered by the treating physician) continuous nursing including the provision of on-going maintenance care. Services cannot be for habilitative care as defined in paragraph (B)(7) of this rule.

(c) Has a comparable level of care as evidenced by either:

(i) Enrollment in a HCBS waiver; or

(ii) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance do these criteria constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long-term care institution.

(2) The provider of PDN services must assure and document the consumer meets

all requirements in paragraph (F) of this rule prior to requesting and billing for the PDN services.

(3) The U5 modifier must be used when billing in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U5 modifier indicates that all conditions of paragraph (F) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.

(4) The child must have a PDN authorization approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or is designee will conduct a face-to-face encounter and/or review of documentation. PDN authorization may be obtained after the delivery of services when required to protect the health and welfare of the consumer, including emergencies. A request for PDN authorization is made as follows:

(a) For a child not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the amount, scope and duration of services authorized.

(b) For a child enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver which will be forwarded to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.

(c) For a child enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.

(5) Must meet all requirements in paragraph (F) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(6) Paragraphs (F)(1)(c), (F)(3) and (F)(4) of this rule will not apply for dates of service provided on July 1, 2006 to September 30, 2006. For the dates of service on or after July 1, 2006 until September 30, 2006, providers of PDN services for children must bill using the U5 modifier, using the physician's order and paragraphs (F)(1)(a)(b), (F)(2) and (F)(5) of this rule as criteria to provide PDN services. ODJFS or it's designee will accept requests for PDN authorization for PDN services provided on or after October 1, 2006 starting September 1, 2006.

(G) Adult - PDN: The adult consumer who meets the following requirements may receive

PDN services.

(1) The adult is age twenty-one or older.

(2) The adult requires (as ordered by the treating physician) continuous nursing including the provision of on-going maintenance care. Services cannot be for habilitative care as defined paragraph (B)(7) of this rule.

(3) The adult has a comparable level of care as evidenced by either:

(a) Enrollment in a HCBS waiver; or

(b) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution.

(4) The provider of PDN services must assure and document the consumer meets all requirements in paragraph (G) of this rule prior to providing PDN. Providers must bill using the U6 modifier in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U6 modifier indicates that all conditions of paragraph (G) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.

(5) The adult must have a PDN authorization approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or its designee will conduct a face-to-face encounter and/or review of documentation. PDN authorization may be obtained after the delivery of services when required to protect the health and welfare of the consumer, including emergencies. A request for PDN authorization is made as follows:

(a) For an adult not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the amount, scope and duration of services authorized.

(b) For an adult enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the

HCBS waiver, who will forward the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.

(c) For an adult enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.

(6) Must meet all requirements in paragraph (G) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(7) Paragraphs (G)(3), (G)(4) and (G)(5) of this rule will not apply for dates of service provided on July 1, 2006 to September 30, 2006. For the dates of service on or after July 1, 2006 until September 30, 2006, providers of PDN services for adults must bill using the U6 modifier, using the physician's order and paragraphs (G)(1), (G)(2) and (G)(6) of this rule as criteria to provide PDN services. ODJFS or its designee will accept requests for PDN authorization for PDN services provided on or after October 1, 2006 starting September 1, 2006.

(H) Consumers subject to medical determinations made by the department or its designee pursuant to this rule will be afforded notice and hearing rights to the extent afforded in division 5101:6 of the Ohio Administrative Code.

(I) Consumers enrolled on HCBS waivers administered by ODMR/DD or ODA who received services that exceeded the state plan benefit for any time period during the one hundred twenty days preceding the effective date of this rule may request that ODJFS or its designee conduct a review to determine if the consumer qualifies to transfer to an ODJFS-administered waiver. To qualify for a transfer to an ODJFS-administered waiver, the consumer must meet the ODJFS waiver eligibility criteria set forth in rule 5101:3-46-02, 5101:3-47-02 or 5101:3-50-02 of the Administrative Code and have a current need for nursing service over fourteen hours (fifty-six units) per week. Consumers requesting a review pursuant to this paragraph shall be notified of the ODJFS determination and offered hearing rights in accordance with division 5101:6 of the Administrative Code.

(J) The provisions of this rule are effective on July 1, 2006.

Replaces:	Part of 5101:3-12-01, 5101:3-12-02, 5101:3-12-03, 5101:3-12-04, 5101:3-12-05, 5101:3-12-06
Effective:	06/30/2006

CERTIFIED ELECTRONICALLY

Certification

06/30/2006

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021, 5111.85
Prior Effective Dates:	4/4/77, 4/7/77, 12/21/77, 6/1/80, 5/1/87, 4/1/88, 5/15/89, 3/30/90 (Emer), 6/29/90, 7/1/90, 3/12/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 4/30/93 (Emer), 7/1/93 (Emer), 7/30/93, 9/1/93, 1/1/96, 5/1/98, 7/1/98, 9/29/00, 3/1/02 (Emer), 5/30/02, 1/31/05, 9/1/05